MDR Tracking Number: M2-03-1264-01
IRO Certification# 5259

June 25, 2003

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
This is a gentleman who was injured on ___. The initial injury appears to be a sub-dural bleed and right shoulder injury. The shoulder was treated with arthroscopic debridement. It is not clear how the back was injured; however, treatment included lumbar surgery and non-steroidal, anti-inflammatory medications, oral analgesics, and muscle relaxers. In May of 2003 ___ sought a purchase of a muscle stimulator. This was denied as not being medically necessary. A reconsideration was requested and noting that the device decreased the complaints of pain, increased the range of motion of the claimant, and the overall muscle condition was improved. The reconsideration reviewer did not feel that there was a medical necessity for this device. The most recent progress notes from ___ noted that the claimant was disabled secondary to the closed head injury. The physical examination on that report focused on the right shoulder and lower back. However, there is no documentation of a reduction in oral medication usage or increased range of motion on physical examination or overall increased improvement in function.

REQUESTED SERVICE (S)
Purchase RS4i Stimulator

DECISION
Endorsement of prior determinations

RATIONALE/BASIS FOR DECISION
The intent of this device is to reduce pain, increase function, and decrease medication usage. ___ alludes to the fact that each was achieved. However, there is no documentation that this was reached. Further, ___ continues to prescribe three medications (Lodine a non-steroidal, anti-inflammatory medication, Ultracet, and oral analgesic and Mobisyl cream for muscle spasm). With the pain level at 2/10, and there being a topical preparation being used for muscle spasm, the purchase of this device appears to be redundant and not clinically medically reasonable and necessary. The Philadelphia Study makes this device no more effective than a placebo. With the medications being prescribed and the current levels of pain there is no clear clinical indication for this implement.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 26th day of June 2003.